Psychology Tomorrow

Date: January 22nd, 2013 *Volume: #1 Issue #1*

A woman with bipolar disorder talking to the therapist, training herself to acknowledge her mental illness.

Bipolar Disorder

Bipolar disorder, also known as manic depression, is a mood disorder that causes severe shifts in mood, thoughts and behaviors. The major symptoms of bipolar disorder involve difficulty in concentrating, remembering and deciding, changes in sleep patterns, diminished energy, persistent thoughts of death, hallucinations and delusions. Unlike normal depression, bipolar disorder divides into two phases: mania and depression. Mania shows extreme excitement, activeness, restlessness, racing thoughts, quick changes of ideas, grandiose self-esteem, poor judgment on goals, impulsiveness, and simultaneous happiness and aggression. In contrast, depression shows pervasive sadness, feelings of guilty, anxious, worthless, and helpless. These two phases shifts in cycle continuously. The duration can be varied depending on individuals; it could be repeating by 6 months, 1 month or even 1 day. As the disorder is neglected, the cycling can get more rapid. Although bipolar disorder is a mood disorder, it can be detected biologically. For instance, CT scans can detect brain's structural disability such as deterioration of cortex and cerebellum ("Bipolar Disorder").

Prevalence

According to a government's survey on more than 61,000 patients, 2.4% of the world population may be diagnosed with the disorder. The survey was taken in numerous nations, and United States scored the highest, as 4.4%. In contrast, India scored the lowest as 0.1% ("Bipolar Disorder Statistics").

The woman introducing her messy room to the therapist and reflecting on why she likes shopping related to her depressive experience.

Exclusive-Bipolar Disorder Made Maia Feel Ruined
https://www.youtube.com/watch?v=Ji0ettWVSI0

Psychology Tomorrow

Volume: #1 Issue #1

Delete box or add photo caption here.

Diagnosis Criteria

Key Words

- **Diagnostic and Statistical Manual of Mental Disorder (DSM)**
- **Bipolar I**
- **Bipolar II**
- **Cyclothymic**

Diagnosis of bipolar disorder is divided into three different types according to Diagnostic and Statistical Manual of Mental Disorder (DSM). First of all, Bipolar I disorder is diagnosed if one has at least one manic or one mixed episode. This means that one may or may not have major depressive episode. Second of all, Bipolar II disorder is diagnosed if one has at least one major depressive episode and at least one hypomanic episode, which does not necessarily be mixed or fully manic. Lastly, Cyclothymic disorder is classified when one has numerous hypomanic episodes and depressive periods. The symptoms needs to last at least two years and can distress some areas of real life ("Bipolar Disorder").

Etiology

Biology

While definitive biological cause to bipolar disorder is still uncertain, a myriad of research studies in recent days are inclined to the strong connection between biology and the disorder. University of California, San Diego (UCSD) School of Medicine identified a specific gene which reportedly causes bipolar disorder. The research team first hypothesized that gene mutation would cause bipolar disorder as it affects individuals to become hypersensitive to dopamine, leading to extreme mood shifts. The study has revealed the six genetic mutations involved with the disorder and several chromosomes which sites for the multiple genes that cause bipolar disorder (Oliver).

Cognition

Another important cause of bipolar disorder is cognitive vulnerability, including irrational beliefs. Beck in 1976 suggested that depressed mood states are formed by patterns of thinking that maximize mood shifts. For instance, as people become depressed, they become more negative in evaluating themselves and others. In contrast, mania is opposite to depression and is characterized by a positive cognitive evaluation on individuals themselves and others. Hyper-positive thinking is typified by cognitive distortions (Scott). This shows that the cognitive vulnerability is the key factor that may lead to bipolar disorder.

Socio-Culture

Other than previously mentioned two aspects, environment takes important role in bipolar disorder, especially the recent life events including traumas and social supports including negative support. It has been consistently identified among research studies of Alloy, Abramson, Neeren et al.,in press; Alloy, Reilly-Harrington et al.; Johnson and Kizer; Johnson and Roberts that individuals with bipolar disorder experience increased stressful events prior to onset or subsequent episodes of the disorder. Moreover, Johnson, Meyer, Winett and Small (2000), Johnson, Winett, Meyer, Greenhouse, and Miller (1999); Miklowitz, Goldstein, Nuechterlein, Snyder, and Mintz, (1988); Priebe, Wildgrube, and Muller-Oerlinghausen (1989), and Rosenfarb et al. (2001) have all found that positive social support from significant relations leads to positive course of bipolar disorder, and negative social support from significant relations leads to negative course of the disorder (Alloy).

Psychology Tomorrow

Key Words

- Social Phobia
- Anxiety and Fear
- DSM-IV

Social Anxiety Disorder

Social anxiety disorder is well known as social phobia. It is a persistent and irrational fear of situations that may involve judgment of others. The symptoms of social phobia describe as extreme anxiety, self-consciousness, intense and persistent fear of being watched and judged. Other than that, it must involve inability of controlling fear even if one realizes it. Social phobia can be limited to one situation or in general, and it involves many other physical symptoms such as blushing, difficulty talking, nausea, profuse sweating and trembling. While social phobia is alike with shyness, it is different from the shyness in the aspect that social phobia can affect the ability to function in work and relationships (Berger).

A girl with social phobia distances herself away from others at her birthday party.
Curing Kids with Extremem Social Phobia
https://www.youtube.com/watch?v=i7EAsMNZ6uA

Diagnosis

Similar to bipolar disorder, diagnosis of social phobia is determined upon DSM-IV. There are seven main criteria to be diagnosed with social phobia. First is marked and persistent fear. Second is anxiety response to the feared situations in form of a panic attack. Third is recognition of irrational fear. This symptom is more prevalent among adults, and children may not recognize their irrational response to the feared situation. Fourth is avoidance or distress of the situation or interaction of people in uncomfortable situations. Fifth is severe disturbance on personal, work or school life due to social phobia. Sixth is at least six months of duration of the disorder. Last is independent cause of the symptoms since many anxiety disorders and physical illnesses share similar symptoms (Fritscher).

Psychology Tomorrow

Volume: #1 Issue #1

Delete box or add photo caption here.

Etiology

Key Words

- Genetic Factors
- Hypersensitive Amygdala
- Negative and Irrational Beliefs
- Learning
- Lack of Social Skills

Biology

Social phobia has various causes to its development. First from biological point of view, genetic factors and hypersensitive nervous systems can lead to social phobia. According to Millon, Blaney, and Davis in 1999, estimated heritability for social phobia ranges from 12% to 60%. Velting and Albano in 2001 and Pine in 1999 found that individuals with social phobia have hypersensitive amygdala, a structure in the limbic system that controls fear and startle response (Ferguson). Neuroimaging research proposed that greater activation of the amygdala to new versus familiar faces may be a potential trait mark for social phobia. The disorder may be demonstrated as a phenotype that expresses a genetically driven trait of social extraction (Cottraux).

Cognitive

Second from cognitive point of view, the major cause to develop social phobia is the negative and irrational beliefs about people themselves. Individuals with social phobia usually have more irrational and negative beliefs, and this leads to negative evaluation of their reputation that causes fear to the socially phobic individuals to avoid interaction with people. In the research of Rapee and Lin in 1992, negative evaluation is explicitly demonstrated among individuals with social phobia. They had two groups of social phobic and control participants to present a brief, impromptu speech. Although the ratings of performance of both groups by audience showed no difference, those with social phobia rated their overall performance as worse than did controls. This suggests that persons with social phobia may perceive their performance more negatively than others. Other than that, learning from previous experience in social settings is also a major cognitive cause to social phobia, as Zuckerman in 1999, and Hoffman, Ehler and Roth in 1995 identified 89% of a group of individuals with social phobia experienced a negative experience that is associated with fear (Ferguson).

Socio-cultural

Last from social-cultural point of view, lack of training social skills can lead to social phobia. This is evident in the research of Alden and Wallace in 1995, which they found that individuals with social phobia were less warm and less interested in others. Lack of social skills is also linked to advanced technology environment. Kraut et al. in 1998 suggested that as more advanced technology is developed, the isolation between people increases and eventually leads to high risks of social phobia (Ferguson). According to M. Arafa et al., a relatively high frequency of social phobia has been observed among Saudi patients seeking psychiatric help. In this study explored the possible role of some sociocultural factors in explaining this phenomenon. The research team conducted on a group of 53 social phobic patients and a control group of 26 individuals with other neurotic disorders to assess the impact of social change. The study focused on social change in terms of upward social mobility, urbanization, change in family structure, and also the cultural patterns such as cultural norms, traditions and customs. The results evident for a highly possible role of sociocultural factors in explaining the phenomenon of social phobia as observed in this culture (Arafa).

Psychology Tomorrow

Key Words

- Benzodiazepines
- Antidepressant
- Venlafaxine-extended release
- Virtual Reality Therapy (VRT)

Treatments

Biomedical

Social phobia can be treated in two big approaches. The most well-known treatment is biomedical. Benzodiazepines can provide relief from the physical symptoms of anxiety and antidepressant is believed as an effective in relieving intensity of social phobia. Some clinicians combine these drug treatments with other psychotherapies to cope with the disorder (Ferguson). Other than that Allgulander et.al evaluated on anxiolytic efficacy, safety and tolerability of a flexible dose of venlafaxine-extended release compared with placebo and paroxetine in the short term treatment of generalized social anxiety disorder. 434 participants with generalized social phobia randomly received capsules of venlafaxine-extended release 75 mg to 226 mg per day, paroxetine 20 mg to 50 mg per day or placebo for 12 weeks in total treatment with venlafaxine was associated with significantly greater improvement than treatment with placebo (Liebowitz).

Bowie, Vickie. *Social Phobia*. Digital image. *Flickr*. Yahoo!, 22 Sept. 2007. Web. 10 Jan. 2013. <http://www.flickr.com/photos/vickiebowie/4338993205/in/photostream/>.

Cognitive Behavioral

Individual

One well-known cognitive behavioral therapy is exposure therapy. However, recently it is replaced by virtual reality therapy which requires a personal computer to run a video program representing various social settings to let patients experience many different social settings. Klinger et al. tested effect of this VRT therapy using a non-randomized control of patients treated with other cognitive behavior therapy. With therapist's help, patients first learned adapted cognitions and behaviors when coping with social situations to reduce their anxiety in real-life situations. Then the research team compared 18 individuals with social phobia who received 9 VRT with another 18 social phobic individuals who received regular CBT in a group setting. At last, the researchers identified that both groups demonstrated an equal improvement in the two conditions from before to after testing on all the measures: social phobia, anxiety, depression, handicap and Clinical Global Impression (CGI). ()

Psychology Tomorrow

Volume: #1 Issue #1

Delete box or add photo caption here.

Treatment

Group

These two cognitive-behavioral therapies are focused on individuals; there is group therapy that the individuals with social phobia gather and resolve the symptoms together. The group therapy is especially helpful for individuals who need to develop their social skills and overcome their anxiety in social settings. The person with social phobia will be able to interact directly with other individuals who can also give feedback about the actual performance of the individual to help challenge some of their negative evaluations (Ferguson).

Thomas A. Richards observed his patient called Jim, who suffered social phobia and eventually overcame it through group therapy. Jim was shy and socially anxious since his teenage years. Even though he formed his own family, he could not handle daily, family responsibilities and push them on to his wife. He works at old record store where the owner was person who he knows well, and thus did not get a job which has direct interaction with people. However, as the owner passed the ownership of the shop to a national record chain, Jim could not avoid any more and did not enjoy his altered position. Jim was cooperative in the progress of treatment. Because the problem that Jim was suffering is merely based on negative self-evaluation, the treatment team had worked on setting up the mind that it has no big deal in making mistakes. Before group therapy, he did a number of interesting things in public that began proving to him that he was not the center of attention, and it just didn't matter if he made a mistake or two. The therapy was successful as Jim mentioned over the phone after the treatment "I can't get too distracted. I've got too many speeches to give now." This case study shows the efficient impact of group therapy on social phobia (Richards).

Key Words

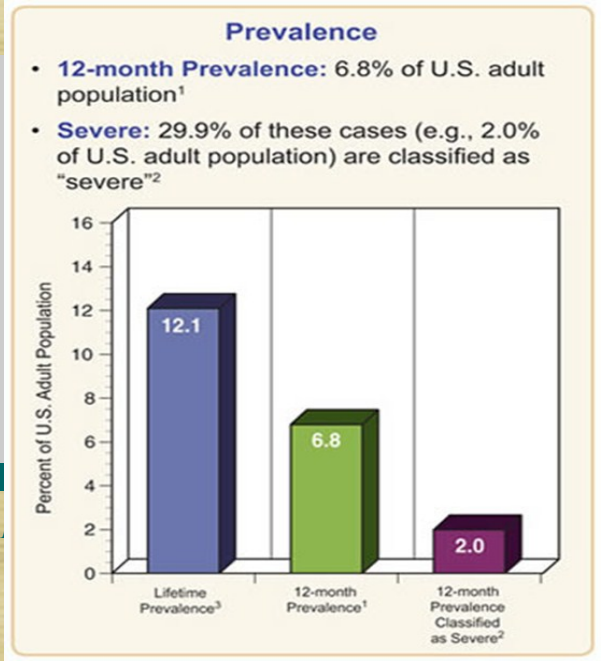
- Group Therapy
- Prevalence

Prevalence

According to the statistics reported by National Institute of Mental Health, 12-moonth prevalence in United States is up to 6.8% of American adult population, and 29.9% of them (2.0% of the total population) are classified as severe. In addition, lifetime prevalence is approximately 12.1% of American adult population ("Prevalence"). The distribution of lifetime prevalence among age of 18 to 59 is considered as even, because each range of the age only distances 1.9% at the most. Between ages of 18 to 29, lifetime prevalence of social phobia reaches 13.6%; between ages of 30 to 44, it scores 14.3%; and between ages of 45 to 59, it reaches 12.4%. However, at the range of 60 year-old and above, the percentage drops to 6.6% ("Demographics (for life time prevalence)").

Psychology Tomorrow

Date: January 22nd, 2013 *Volume: #1 Issue #1*



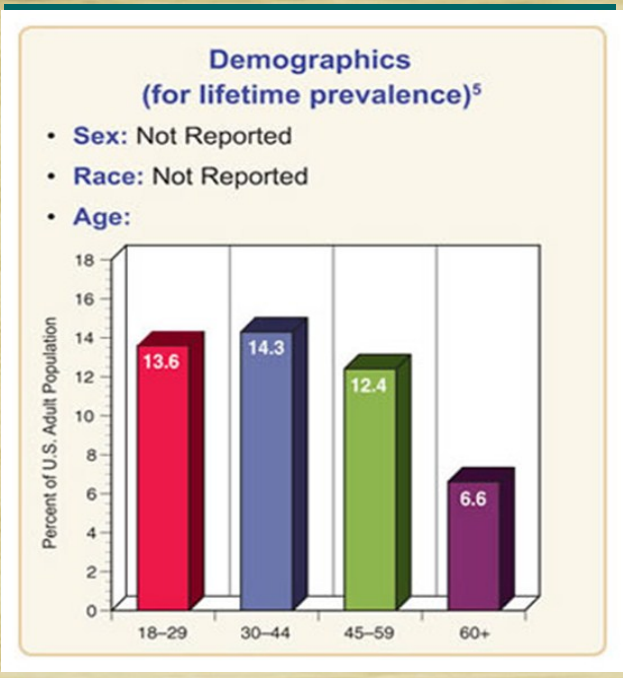
"Demographics (for lifetime prevalence)." Chart. *Social Phobia Among Adults*. National Institute of Mental Health. Web. 16 Jan. 2013. <http://www.nimh.nih.gov/statistics/1SOC_ADULT.shtml>.

Evaluation of Treatments

While all treatments mentioned above help to cope with social phobia, the most effective way to treat the disorder is to combine drug therapy and group therapy. As the estimated heritability of social phobia from previous generation rate 12% to 60%, biological cause takes significant part in social phobia. Considering the research that Allgulander et.al conducted, venlafaxine-extended release seems to be the most effective drug treatment. However, while there was significant improvement compared to placebo, there was no significant difference observed between the venlafaxine and paroxetine groups. This demonstrates that among many types of drugs, there are no definite one that stands out from others, instead the individuals with social phobia would find the best impact of drug treatment when they are prescribed with the drug that corresponds best to their biological condition. Biologically relieving anxiety and fear encountered in social settings would help individuals with social phobia to relax.

As the individuals are relieved physically, group therapy would be helpful in terms of reducing fundamental problem. The study of Klinger et al. suggests virtual reality therapy (VRT) is showing its great efficacy in coping with social phobia, as all 18 individuals with social phobia who were in VRT sessions showed significant improvements afterwards. However, the limitation of this study shows that this individual therapy might not be the best out of other cognitive strategy, as there was no significant difference between the outcomes of the 18 patients in VRT sessions and the other 18 patients in CBT. In contrast, group therapy shows significant efficiency on its outcome as shown in Richard's case study on Jim. Because group therapy allows the individuals both to be exposed to the social settings and to develop their social skills, it triggers to beneficial outcomes. Moreover, as Richards trained Jim to escape from the loop of negative beliefs, direct feedback during the treatment would also encourage individuals to be cooperative at progress.

Socially phobic individuals are usually rooted with negative thoughts and are lack of social skills. Thus, reducing those thoughts and developing social skills can help to cope with unnecessarily fear of being watched and judged by others. If the individuals find balance in both physical and psychological status, the effort to treat social phobia would be optimized to maximize the outcomes. Therefore, the combination of drug and group therapy would cope with the individuals with social phobia the best.



"Prevalence." Chart. *Social Phobia Among Adults*. National Institute of Mental Health. Web. 16 Jan. 2013. <http://www.nimh.nih.gov/statistics/1SOC_ADULT.shtml>.

Works Cited

Alloy, Lauren B., Lyn Y. Abramson, Snezana Urosevic, Patricia D. Walshaw, Robin Nusslock, and Amy M. Neeren. *The Psychosocial Context of Bipolar Disorder: Environmental, Cognitive, and Developmen tal Risk Factors*. N.p.: Clinical Psychology Review, 13 June 2005. PDF.

Arafa, M., M. Al-Khani, and E. Hamdi. *Social Phobia in an Ar ab Culture: The Impact of Sociocultural Factors*. Egypt: J. Psychiat, Jan. 1992. PDF.

Berger, Fred K., and David Zieve. "Social Phobia." *Social Pho bia*. U.S. National Library of Medicine, 7 Mar. 012. Web. 29 Dec. 2012. <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001953/>.

"Bipolar Disorder." *NIMH Â·*. Web. 28 Feb. 2012. <http://www.nimh.nih.gov/health/publications/bipolar-disorder/complete-index.shtml>.

"Bipolar Disorder Statistics." *Bipolar Disorder Statistics*. Depression and Bipolar Support Alliance (DBSA), 28 Feb. 2012. Web. 17 Jan. 2013. <http://www.dbsalliance.org/site/PageServer? Page name=education_statistics_bipolar_disorder_5066265_etiology->/

"Demographics (for lifetime prevalence)." Chart. *Social Phobia Among Adults*. National Institute of Mental Health. Web. 16 Jan. 2013. <http://www.nimh.nih.gov/statistics/1SOC_ADULT.shtml>.

Cottraux, Jean. *Recent Developments in Research and Treatment for Social Phobia (Social Anxiety Disorder)*. France: Current Opinion in Psychiatry, Feb. 2005. PDF.

Ferguson, Darris. "Social Phobia." *Etiology and Risk Factors*. Appalachian State University, Web. 01 Jan. 2013. <http://www1.appstate.edu/~hillrw/SocialPhobia/Etiology.html>.

Fritscher, Lisa. "Diagnosing a Social Phobia." *About.com Phobias*. About.com, 07 Feb. 2009. Web. 30 Dec. 2012. <http://phobias.about.com/od/symptomsanddiagnosis/a/socphobiadiag.htm>

Liebowitz, Michale R., Alan J. Gelenberg, and Dennis Munjack. "Venlafaxine Extended Release vs Placebo and Paroxetine in Social Anxiety Disorder." *JAMA Psychiatry*. American Medical Association, Feb. 2005. Web. 20 Jan. 2013.

"Prevalence." Chart. *Social Phobia Among Adults*. National Institute of Mental Health. Web. 16 Jan. 2013. <http://www.nimh.nih.gov/statistics/1SOC_ADULT.shtml>.

Richards, Thomas A. "Social Phobia/Anxiety Case Study: Jim." *The Anxiety Network*. The Anxiety Network, Web. 20 Jan. 2013. <http://www.anxietynetwork.com/content/social-anxiety-case-study>.

Scott, Jan. *Cognitive Therapy as an Adjunct to Medication in Bipolar Disorder*. The British Journal of Psychiatry, 2001. PDF.

Oliver, David. "Bipolar Disorder Articles and Stories." *Genetics and Bipolar Disorder*. BipolarCentral. Web. 20 Jan. 2013. <http://www.bipolarcentral.com/articles/articles-125-1-Genetics-and-Bipolar-Disorder.html>.